

Town of Arlington- Workers' Compensation Department
REPORT OF OCCUPATIONAL INJURY OR ACCIDENT

This form MUST BE COMPLETED IN FULL and forwarded to Workers' Compensation Department, 50 Pleasant Street, Arlington, MA 02476 WITHIN 48 HOURS OF THE TIME OF INJURY OR ACCIDENT. PART I (Sections A to G) to be completed by the employee. Part II (sections H and I) to be completed by the supervisor. If you have any questions about the completion of this report or worker's compensation matters, call 781-316-3154. PLEASE PRINT OR TYPE.

PART I

SECTION A- EMPLOYEE INFORMATION

Last Name:		First Name:		Middle Initial(s):	
Home Address:		City:		State:	Zip Code:
Home Telephone:		Cellular Phone:		Social Security #:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Married <input type="checkbox"/> Single
Date of Birth: (Month/Day/Year)		Date of Hire with the City: (Month/Day/Year)		Date of Hire in Current Dept: (Month/Day/Year)	
No. Hours Worked Per Day:	No. of Days Worked Per Week/Shift:	Regular Working Days: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		Hourly Wage/Weekly Rate:	
Regular Occupation:		Occupation at time of accident:		Was employee performing regular occupation when accident occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has this employee ever claimed Workers' Compensation before? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, Date Worker's Comp last claimed: (Month/Day/Year)	

SECTION B- DEPARTMENT INFORMATION

Department/School/Budget Program Name:			
Department Address:		City:	State: Zip Code:
Telephone:		Fax:	

SECTION C- INJURY/ACCIDENT INFORMATION

Date of Injury/Illness/Accident:		Time of Injury/Illness/Accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Date of Injury/Illness/Accident Reported:	
Name of person that the injury was reported to?		Position:	Telephone No:	Was more than 4 hours of work lost on the date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will time be lost beyond the date of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		If accident resulted in death, Date of Death:		First Lost Work Day: (Month/Day/Year)	
Regular Start Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Regular End Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Did accident occur on the City Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, provide address:	
Name of witness:		Address:		Telephone No.:	

SECTION D- TREATMENT, REHABILITATION, & RETURN TO WORK INFORMATION

Was the injured worker transported for treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, form of transportation: <input type="checkbox"/> Ambulance <input type="checkbox"/> Drove Self <input type="checkbox"/> Supervisor <input type="checkbox"/> Other		Was any treatment given at the accident site? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of treating Physician:		Address of treating Physician:		Date of treatment: (Month/Day/Year)	
Name of treating Hospital:		Address of treating Hospital:		Date of treatment: (Month/Day/Year)	
Are you a Medicare beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is your Medicare ID#?					
Date of Return to Work (if applicable):					

First Point of Contact for non-emergency injuries is AFC Urgent Care Arlington, 1398 Mass Ave., Arlington, MA 02476
781-648-4572 / www.afcurgentcarearlington.com. Check in online for shorter wait time.

REPORT OF OCCUPATIONAL INJURY OR ACCIDENT --Page 2 --

SECTION E- NATURE OF INJURY OR ILLNESS

Nature of injury or illness to Body Parts (Burn, Fracture, Cut etc.)
Specific Body Part injured: (left shoulder, right knee, lower back etc.)
Source of injury or illness (e.g machine, etc.)

SECTION F- THE ACCIDENT

Describe the circumstances leading up to and including the accident:
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What do you think was the source of this accident? (e.g faulty equipment etc.)
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SECTION G- EMPLOYEE'S VERIFICATION OF REPORT

I hereby verify that all of the information contained in this report of occupational injury or accident is accurate to the best of my recollection of the circumstances leading up to and including the incident which caused the injury.	
Employee's Name (PRINT):	Occupation:
Employee's Signature:	Date Report Completed: (Month/Day/Year)

PART II - TO BE COMPLETED BY SUPERVISOR

SECTION H- CORRECTIVE ACTION

To your knowledge has a follow-up investigation been conducted into this report of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, are you aware of any correction action taken to prevent a similar accident from happening? (e.g. equipment repaired etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you have any additional recommendations for preventing injuries of this type?
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SECTION I- SUPERVISOR'S ACKNOWLEDGEMENT THAT ACCIDENT WAS REPORTED

Supervisor's Name (PRINT):	Title:
Supervisor's Signature:	Date Report Completed: (Month/Day/Year)